Innovative Resource Group d/b/a

APS Healthcare

APS Healthcare – West Virginia
APS Complete CareConnection® (C^3)
for WV Pre-Admission Screenings (PAS)
for Nursing Home Care

PAS Web Submitter User's Manual

Table of Contents

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Practice the submission of WV-PAS via the APS Complete CareConnection®
(C^3) Web Site at **https://c3-training2.apshealthcare.com**

**Submit WV-PAS via the APS Complete CareConnection® (C^3) at
https://c3.apshealthcare.com**

For APS C^3 for PAS Web Site Technical Assistance Call APS Healthcare Toll-
Free at 1-800-461-0655

I.   Overview/Technical Requirements

Overview

The APS Complete CareConnection® (C^3) WV PAS Web Application allows users to submit WV Pre-Admission Screenings for Nursing Home Care via the web.

Technical Requirements

1. You must have a computer with Internet access. The APS C^3 Application supports only Internet Explorer (IE) 7.0 and higher.

2. Your computer must be connected to a printer to print a PAS.

3. If you are experiencing difficulties logging on or using the web application, please do the following:
    -   Check to confirm that your browser's security settings are set to 128-bit encryption. This can be done in your Microsoft Internet Explorer session by clicking "**Help**" and then click "**About Internet Explorer**." The resulting display will specify the version of Internet Explorer you are running, along with the encryption specification in terms of "**Cipher Strength**".

    -   Upgrade your browser to Internet Explorer (IE) 7.0 or higher

        ✓ Warning: you must have Windows 98 or higher.

        ✓ To download a free upgrade of IE you may visit
           http://www.microsoft.com/windows/ie/downloads/ie7/default.asp or consult your organization's technology staff/department.

    -   Reset your Internet security to Medium

        ✓ Right Click on your IE icon

        ✓ Choose "Properties"

        ✓ Select the "Securities" tab

        ✓ Click "Default" level.

This application follows Health Care Financing Administration (HCFA) security regulations and will comply with Health Insurance Portability and Accountability Act (HIPAA) regulations. Consequently, there are multiple levels of security. For more information on the security of this online application, please contact APS Healthcare, Inc. at 304-343-9663.

II. The Login Process
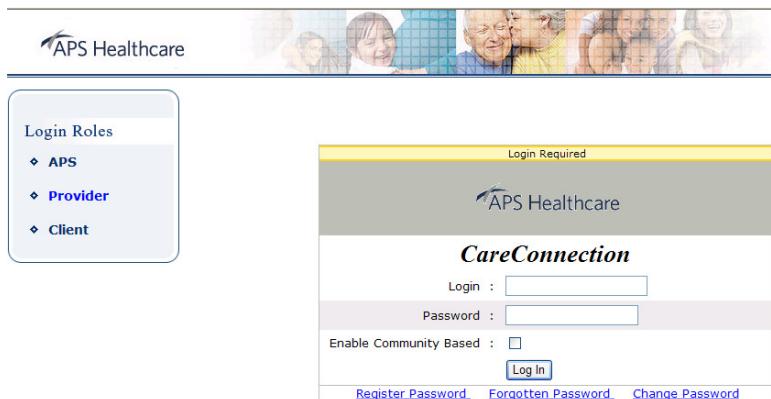
Figure 2.1

1. Access the WV PAS Application training website at https://c3-training2.apshealthcare.com or the APS C³ Production (Live) Web Application at https://c3.apshealthcare.com/

2. For this application, you may ignore the **Login Roles** box on the left.

3. Enter your **Login** and **Password, which** were sent to you by an APS Associate**,** then click the ***Log In*** button**.** Note that your **Login** and **Password** are both case sensitive.

4. **If this is your first time logging onto the application**, please use the temporary password issued to you by APS Healthcare. If you have not received a temporary password, please contact APS Healthcare at 304-343-9663 or 1-800-461-0655. The initial password provided to you is a temporary password. The first time you visit the application, the system will tell you that your password has expired and will prompt you to change your password.

   <u>Password Requirements</u>
   - Users' passwords must contain at least one numeric digit (1, 2, 3, 4, 5, 6, 7, 8, 9, 0)
   - The password must be between 6 and 10 characters in length.
   - Users must change their passwords every 30 days. Once a password is changed, the user cannot use the previous passwords for 90 days.
   - After three unsuccessful log in attempts, the user's account will be locked. To request your account be unlocked please contact APS Healthcare at 1-866-461-0655.

5. **NOTE:** Login and Passwords are assigned to individuals who will be held responsible for any action taken by that Login. For this reason, it is strongly encouraged that login information not be shared. Your organization can have as many users as necessary for your work to be completed. To establish web users an **APS Web User Request Form** may be completed (the form is attached to this manual). After submission of your user request form to APS Healthcare, an APS associate will contact the user with his/her new user name and password.

   If you are already an APS user on the West Virginia C³ Medical UM CareConnection® application you may request the same user log in ID and change the temporary password to the same password

III. Getting Started

The first screen that web users will see upon logging into the APS C³ application is depicted in Figure 2.2 below. Note that your **User Role** will be displayed here in the upper left corner.

There are two tabs in the upper left quadrant: **Home** is the current screen you are viewing. The other tab in the upper left-hand corner is labeled **WV PAS Provider.**

If you wish to change your password, click on the **Change Password** link.

Changing Your Password

To change your password, once you log into the system you will see these menu items on the home screen as shown in Figure 2.3

Figure 2.2

During the Change Password process, you are asked to type your old password, choose a new password, and confirm the new password by typing it again.
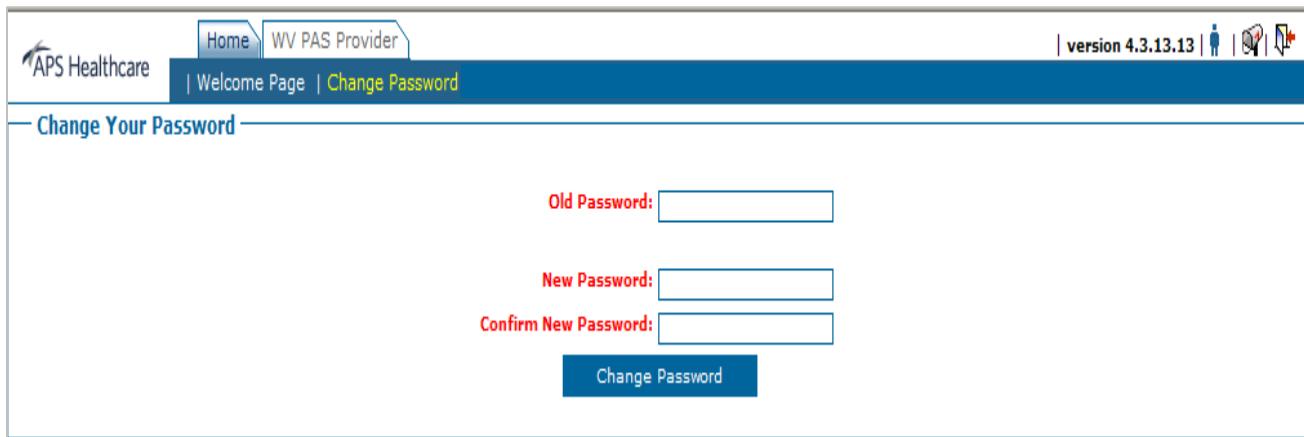
Figure 2.3

If your password is updated successfully then you will see a message box informing you of that fact, as seen in figure 2.4.
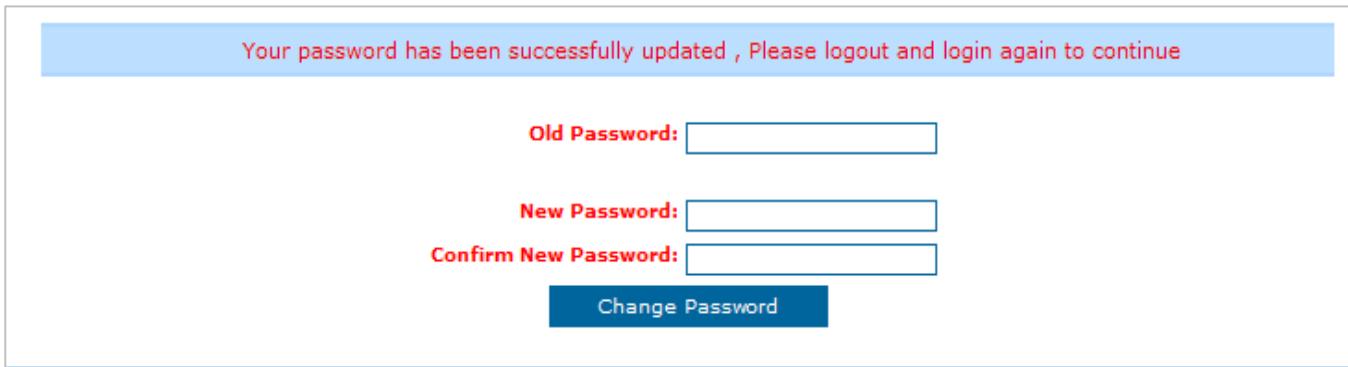
Figure 2.4

If your password did not change successfully then you will see a screen as shown in Figure 2.5, with a message explaining why the failure occurred. (In this case, the failure occurred because the new password was too short.)
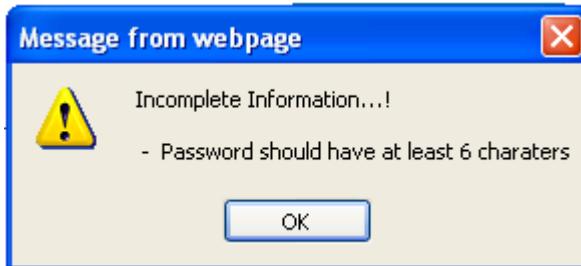

Figure 2.5

Getting Started

From the home screen, click the **WV PAS Provider** tab to begin working on the PAS functions.
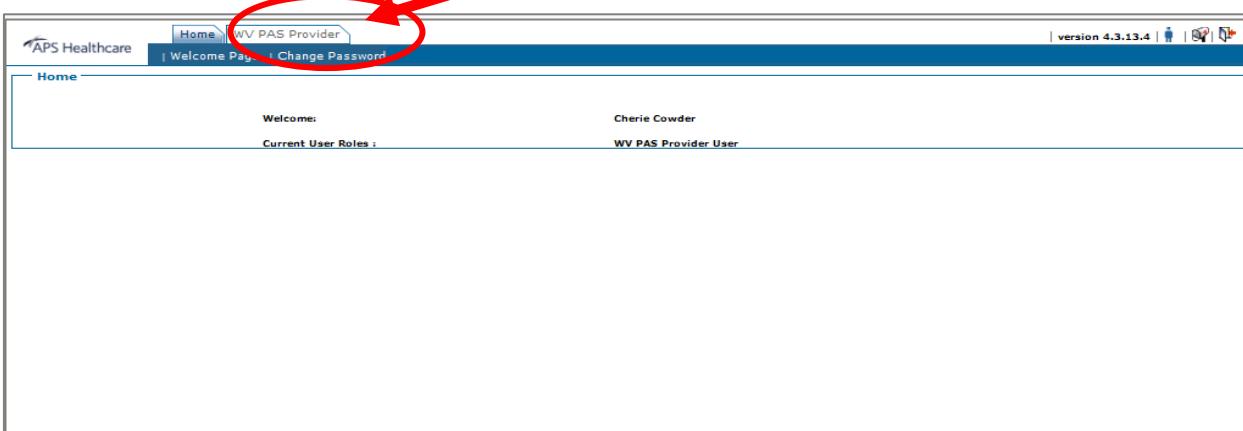
Figure 2.6

You will then be taken to the screen below, Figure 2.7. If you are wanting to submit a new PAS, the first thing you should do is perform a search for existing PAS Forms to assure individual for

who you want to submit a Pas does not yet exist in system. To search existing PAS records, click **PAS Search**.
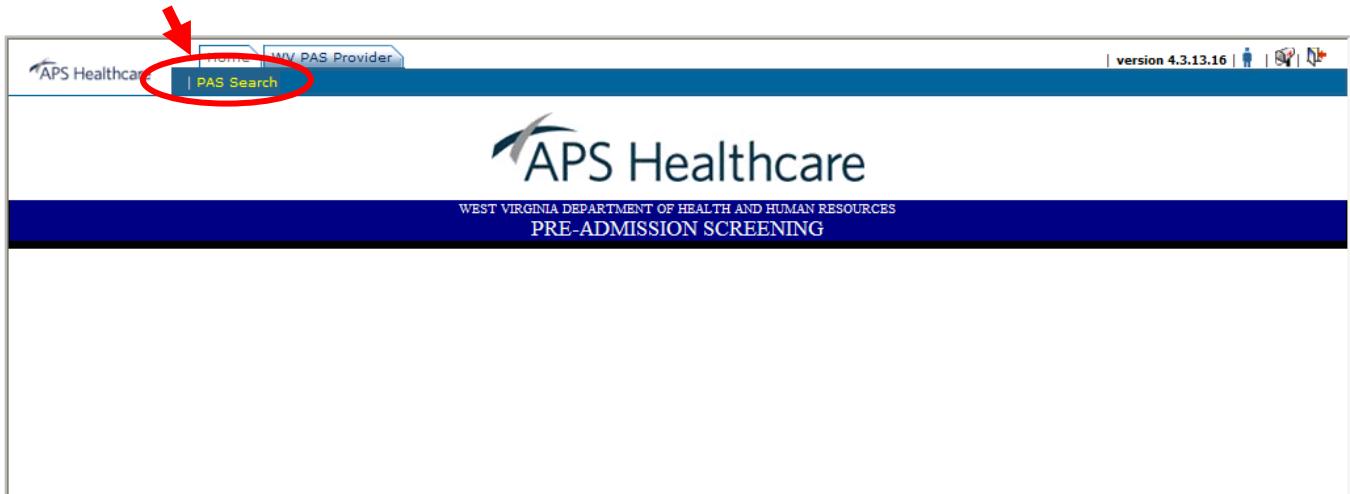
Figure 2.7

If you would like to see all PAS submitted by your organization then chose **ANY** from the PAS Status drop-down bar on the right side and click SEARCH. You will be navigated to the screen below.

Figure 2.8

Enter any of the following and then click **SEARCH** to execute a search for a specific member's PAS or group of PAS records:

- Member last name
- Member first name
- Medicaid or Medicare ID
- Date of Birth
- Facility/Agency/Person Making Referral FROM – You can only search for your agency if you try to search another agency no forms will appear.
- Facility/Agency/Person Making Referral TO - You can only search for your agency if you try to search another agency no forms will appear.
- Member SSN
- PAS Status
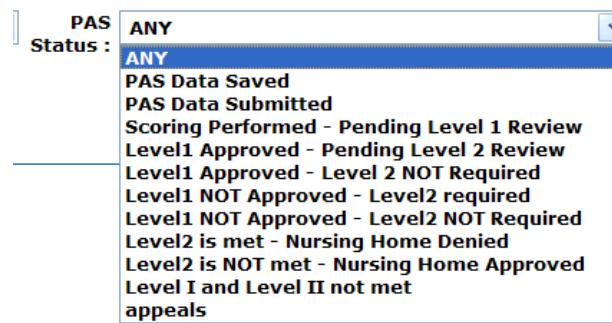
Users may also search by the following statuses:
- ANY
- PAS Data saved (*still editable-not yet submitted to WVMI*)
- PAS Data Submitted (*no longer editable-submitted to WVMI*)
- Scoring Performed-Pending Level 1 Review (*nurse has completed initial scoring-no disposition yet*)
- Level 1 Approved-Pending Level 2 Review – (Level 1 indicates deficits meet Medicaid NH Level of Care/Level 2 review is requested)
- Level 1 Approved-Level 2 NOT required – (Level 1 indicates deficits meet Medicaid NH Level of Care/Level @ is not required)
- Level 1 NOT Approved-Level 2 required – (Level 1 review indicates insufficient deficits documented to meet Medicaid NH Level of Care/Level 2 review is required)
- Level 1 NOT Approved-Level 2 NOT required – (Level 1 indicates insufficient deficits documented To meet Medicaid NH Level of Care/Level 2 is not required)
- Level 2 is met-Nursing Home Denied – (Level 2 review is complete and NH admission is **not** approved)
- Level 2 is NOT met-Nursing Home Approved – (Level 2 review is complete, member may enter NH and Level 1 is approved)
- Level 1 & Level 2 not met –(Level 2 review is complete and NH admission is not approved and Level 1 review indicates insufficient deficits documented to meet Medicaid NH Level of Care)
- Appeals – If you select appeals another drop down box will appear with 9 statuses to choose from:

Appeals Status
- Appeal Requested – Member has requested appeal and BMS has notified APS that appeal is requested
- Appeal Requested – No – The default when there is a denial of NH admission
- Hearing Cancelled – The schedule hearing has been cancelled

- Hearing Rescheduled – If a hearing is cancelled and rescheduled this status is used when the new hearing date is scheduled
- Hearing Held – Yes – A hearing was held – notes are entered by the Nurse Reviewer/Physician Reviewer attending the hearing
- Hearing Held – No – The hearing was rescheduled and not held or appeal was withdrawn
- Denial Upheld – The denial was upheld at hearing no change to the determination is required
- Denial Overturned – The denial was **not** upheld at hearing and PAS requires updating
- PAS is updated NH approved – An administrator has reversed the denial

Entering New Forms

If you wish to enter a new form then click "**Add New Form**" and you will be taken to a blank PAS form for entry:

Figure 3.0

NOTE: To see the whole screen at the same time (without having to scroll left and right) hold down the Control button (in the bottom left-hand corner of the keyboard) and use the scroll wheel on your mouse to reduce the size of the screen until it all fits.

IV. Entering the PAS

Note in the upper left-hand corner the PAS Status box, shown below. This states that you are entering a NEW PAS FORM.

Underneath this box are two blue hyperlinks (as shown in figure 3.1): the **Status** link will take you to the **PAS STATUS** box and the **LEVEL 0** link moves the screen to the fields the provider is to enter. **Level 0** is comprised of all the fields entered by the provider.

In the LEVEL 0 box there are blue hyperlinks (figure 3.1) for the following sections:
- Referrals
- Demographic Info
- Medical Assessment
- MI/MR Assessment
- Physician Recommendations
- Save/Submit

All fields in Level 0 can be edited repeatedly and saved by clicking the Save for Later *button at the bottom of the PAS form. Please note that once the SUBMIT button is clicked; the PAS form is no longer editable by the provider. If any mandatory fields are omitted, the PAS will not submit when the SUBMIT button is clicked and the provider will be prompted by red shading what fields need completed before submission can occur..*

Please note: *The application will time out after 20 minutes of inactivity. The user will receive 2 warnings that they will be timed out and prompted to save their data.*

Figure 3.1

ATTENTION – All Required fields are marked with an asterisk (*). If any of these fields are left blank your submission will not be complete, rather you will receive error messages listing the incomplete required fields.   Once completed, your submission will be successful.

<u>ENTRY FIELDS:</u>

*Referral FROM   Choose from drop down box and the address, phone and fax number will be auto-populated based upon data in our provider database.

This field will auto populate to the provider that is currently logged into the system. If there is an error in the provider information, changes can be made on this form although the changes will not be reflected in our provider database. Changes to the database must be made by the Data Contact for that agency. Please contact APS Healthcare for any changes needed to the provider information at 1-800-461-0655.

Figure 3.2

Contact Person   Enter the name of the individual WMVI staff can contact if there are questions regarding the referral.

Referral TO   Choose from drop down box and the address, phone and fax number will be auto-populated based upon data in our provider database.

If the provider name is not listed in drop down then choose **OTHER** and type in the address, phone and fax. If you do not know the Referral To agency, this field can be left blank. If there is an error in the provider information, changes can be made on this form although the changes will not be reflected in our provider database. Changes to the database must be made by the Data Contact for that agency. Please contact APS Healthcare for any changes needed to the provider information at 1-800-461-0655.

Contact Person   Type the name of the individual we can contact if we have any questions regarding who the referral is to or from. (Note this does not auto populate like address does).

*Reason for screening   Select from drop down box one of the mandatory choices:
- **Nursing Home Only Initial**
- **Nursing Home Only Transfer**
- **Nursing Home Waiting Waiver Yes**
- **OTHER** (if this box is chosen the text box beside it opens and the provider must enter an explanation)

DEMOGRAPHIC INFORMATION

Figure 3.3

*1. Name   First and Last names are mandatory-the PAS will not submit without these fields completed. Middle name (1b) and Suffix (1d) are optional fields.

*2. Gender   Male or Female must be selected.

3. Medicaid   Enter the consumer's Medicaid number if applicable

4.	**Medicare**	Enter the consumer's Medicare number if applicable
*5.	**Address**	Enter consumer's address and city. For state, WV is chosen by default, but other states can be selected if necessary. Zip code must be 5 or 9 digits. Any length that is not equal to 5 or 9 will error out as invalid zip.
6.	**Private Insurance/Private Pay**	Select the appropriate radio button to indicate if the consumer has private insurance. If yes, a text field will open so that the name of the private insurance can be entered. Note: you must complete 3, 4, or 6 in order to submit the PAS. If Private Pay indicate Private Pay.
*7.	**County**	Select from the drop-down list the county where the consumer resides. If other states are selected, county will be disabled.
*8.	**Social Security**	Enter the consumer's 9-digit Social Security Number. (Ex: 999999999 – no dashes)
*9.	**Date of Birth Number**	Enter the applicant's date of birth as follows mm/dd/yyyy. You can also select the calendar 🗓 and select the date from it.
10.	**Age**	Age will automatically calculate based on the date of birth entered.
11.	**Phone Number**	Enter the consumer's phone number without hyphens
12.	**Spouse**	(a-d) Optional fields-enter only if consumer has a spouse.
13.	**Spouse address**	(a-e) Optional – enter only if spouse's address is different from consumer's address
*14.	**Current living arrangements**	Required field. Please indicate where the consumer resides at the time of PAS submission.

Figure 3.4

15.	**Provider name and address**	(a-g) Optional fields. Enter information for provider of current services.
16.	**Medicaid Waiver Recipient**	Select the appropriate radio button to indicate if the consumer is a Waiver recipient. If YES is selected, a drop=down box will be enabled and you must select the consumer's Waiver program (i.e. A&D, I/DD Waiver formerly MR/DD Waiver).
*17.	**Has the Waiver option been explained?**	Response required, please indicate if the option of Medicaid Waiver has been explained to the consumer.
*18.	**Release of medical records**	Click in the appropriate box to select only one of the two options presented.

The first box states "*that the person indicated above has signed the completed PAS and a copy of this document containing the above named applicant's signature (or person signing for the applicant) is on file in the applicant's record.*"

If this is the case, it is expected that the PAS signed by the consumer or their representative is maintained in the consumer's record. The person who actually signed the PAS form (i.e. the consumer or their representative) must be entered into the **Signature** box and their relationship to the consumer entered into the **Relationship** box

The second box states that "*verbal consent was received from the applicant then checking this box certifies that the PAS has been signed by two witnesses and is on file in the applicant's record.*" If this option is chosen the consumer's name is entered into the **Signature** box and "applicant" should be entered into the **Relationship** box. Verbal consent must have been witnessed by two professional (e.g. nurse) witnesses and their signatures must be on the hard copy of the PAS that is maintained in the consumer's record.

In both cases, the date that the PAS form was signed must be entered into the **Date** box using dd/mm/yyyy format or by using the attached calendar feature.

| 19. | **Representative** | Select any and all boxes to indicate whether the consumer has any representatives or a Living Will. When a box is checked a dialogue box as shown in Figure 3.5.1 will appear. |

19. Check if applicant has any of the following:
- ☐ a. Guardian
- ☐ b. Committee
- ☐ c. Medical Power of Attorney
- ☐ d. Power of Attorney
- ☐ e. Durable Power of Attorney
- ☐ f. Living Will
- ☐ g. Other

Figure 3.5

Figure 3.5.1

In some cases the name of the person is required. For guardian the address and phone must be listed. The information for each item indicated must be saved before moving to the next item.

MEDICAL ASSESSMENT

II. Medical Assessment

20. Health Assessment - Include infectious diseases, nutritional needs, prior treatments, degenerative conditions, recent hospitalization(s), and/or surgery(ies) <u>with dates</u> - date of most recent office visit. (Attach most recent Hospital Discharge Summary and Physical, if available.)

☐ Checking this box certifies that the attached document(s) contains the most recent health assessment data available for this member and that the most recent hospital discharge summary and physical has been attached, if applicable.

21. Normal Vital Signs for the individual:
a. Height (inches or cm)   b. Weight (pounds or kg)   c. Blood Pressure (mmHg)   d. Temperature (°F or °C)   e. Pulse   f. Respiratory Rate
[inches ▾]   [pounds ▾]   [/   ]   [°F ▾]

22. Check if abnormal:
☐ a. Eyes   ☐ g. Breasts   ☐ m. Extremities   ☐ s. Musculo Skeletal
☐ b. Ears   ☐ h. Lungs   ☐ n. Abdomen   ☐ t. Skin
☐ c. Nose   ☐ i. Heart   ☐ o. Hernias   ☐ u. Nervous System
☐ d. Throat   ☐ j. Arteries   ☐ p. Genitalia Male   ☐ v. Allergies
☐ e. Mouth   ☐ k. Veins   ☐ q. Gynecological   Specify:
☐ f. Neck   ☐ l. Lymph System   ☐ r. Ano-Rectal

Describe abnormalities and treatment:

Figure 3.6

*20. **Health assessment**	The health assessment is required and the information can be typed into the free-text field. Alternatively, a copy of the consumer's physical examination can be attached as a Word document or picture file (e.g. jpeg, pdf) to the PAS after it has been submitted. After submission, open the PAS again and you will find the Attachment box. Browse for the file to be attached on your computer and attach. If the assessment will be attached please type "attached" in the free- text box	
	You can also indicate in the notes section that the information has been faxed (include the date sent and the information will be attached to the record by APS/WVMI)	
21. **Vital Signs**	a. Height: enter numbers and then choose inches or cm from the drop down box b. Weight: enter numbers and then choose pounds or kg from the drop down box c. Blood pressure: enter in standard mm/Hg units (up to three digits for each entry). d. Enter temperature using 2 or 3 digits and you must have a decimal, then choose degrees F or degrees C from the drop-down box e. Enter pulse as numbers f. Enter Respiratory rate as numbers	
22. **Abnormalities**	Check all that apply for the consumer and then explain the abnormalities in the free-text box. If allergies are chosen, then a free-text field is enabled to specify the allergies.	

Figure 3.7

23. Medical conditions/symptoms

Indicate grade for each condition listed (0 – None, 1 – Mild, 2 – Moderate, 3 – Severe). The default score is 0. If you choose other a text box will be enabled.

*24. Decubitis

Answer Yes or No by clicking the appropriate radio button.

If **YES** a blue hyperlink will appear that states [Add Location] Clicking on the "**Add Location**" link will open a dialogue box with the following fields below:

- *Location* – use drop down box or choose other
- *Description* – This field is only enabled if you choose OTHER
- *Stage* – choose one from drop down box
- *Size* –numerical entry
- *Treatment* – indicate the current treatment
- *Developed* – Indicate where the consumer was when the decubitis was developed

Figure 3.7.1

Save the information and the entries will then be displayed under

the Yes/No radio buttons in the Decubitus box.

If you need to remove the entry, place a check in the **Remove** box as shown in figure 3.7.2. You will be asked you if you are sure you want to remove the entry. If yes, then click **OK.**

24. Does applicant have a decubitus?						
⊙ Yes ◯ No						
[Add Location]						
Remove	Location	Description	A. Stage	B. Size	C. Treatment	Developed at:
☐	Left Leg		1	1	1	Hospital

Figure 3.7.2

*25.   Vacating building

Choose the appropriate answer from the drop down box.

Clinical note: *Counts as deficit if mentally or physically unable to vacate; Should correspond with remainder of PAS; Independently or Supervision means that no hands-on assistance would be required.*

*26.   Level of functioning

Choose 1, 2, 3, 4, 5 as applicable for each section. (5 is only an option for Orientation.)

Item descriptions can be found to the right of each listed item.

Clinical note: Vision, Hearing & Communication are not counted when determining deficits. Eating, Bathing, Dressing & Grooming: Counts as a deficit if level 2 or 3 AND should correspond with each other as well as other areas of the PAS.
- Eating: Level 3 = does not participate at all; Level 4, choose if tube feeding is SOLE source of nutrition; no PO taken.
- Bathing: Level 3 = does not participate in any element of bathing & requires total care. If applicant requires assistance in/out of tub or shower this counts as hands-on, even if bathes independently.
- Continence: Level 4 = catheter or colostomy.
- Orientation: Forgetfulness is not the same as being disoriented.
- Transferring/Walking: Level 2 = Supervised/Assistive Device, but no hands-on assistance required.
- Wheeling: wheelchair must be used in the home. Level chosen should be consistent with level response to "Walking."
- Communication: Level 4 = unable to understand.

Figure 3.8

27.	**Professional and technical care needs**	Check all the needs that the consumer requires.

Checking **OTHER** opens a free-text box in the lower right-hand which then requires an entry.

Clinical note*: Only one deficit is counted regardless of the number of areas indicated, but check all that apply.*

*28. Capable of administering medications

Select the answer that applies to the consumer from the drop-down box. Add comments if necessary.

Clinical note*: Yes = takes appropriate meds at appropriate time via appropriate route; With Prompting Supervision = requires set up or reminders but is able to place pill in mouth independently; No = cannot place meds in mouth.*

29. Current medications

Click link to add medications [Add Medication] A dialogue box will open that allows you to enter the following:

- Medication
- Dosage/Route
- Frequency – Select from dropdown box
- Reason Prescribed
- Diagnosis

If you wish to attached medication list check the box that certifies that a Medication list will be attached - Seen in Figure 3.8.2

Figure 3.8.1

If you need to remove the entry, place a check in the **Remove** box as

shown in figure 3.8.2. You will be asked you if you are sure you want to remove the entry. If yes, then click **OK.**

Figure 3.8.2

MI/MR ASSESSMENT

Clinical note: _Part of screening to determine need for a Level II evaluation for Nursing Home. Review for Level II is a federal requirement to assess the possible need for specialized services._

Figure 3.9

30.	**Current Diagnosis**	Check all that apply date of last PAS Level II Evaluation optional.

If you select options **d**, **f**, or **n** you will be required to enter information into the free text fields.

31. Ever received services from agency for MR/DD or MI

Check Yes or No

If yes, box will appear to enter agency name, address, city. State, zip, county and admission and discharge date (dates optional)

Name of agency and address is only requirement

Add as many agencies as necessary Using the dialogue box as shown In Figure 4.0

Adding Agency	
Name:	
Address:	
City:	
State:	Select...
County:	Select...
Zip:	
Admission Date	Discharge Date
(mm/dd/yyyy):	(mm/dd/yyyy):

Save   Cancel

Figure 4.0

*32. Medications in last 2 years

Check Yes or No

If Yes the Medication List will be enabled and you can check all that apply. If you need to add a medication that is not listed click

[Add Medication]

If you wish to attach a list of current medication place a check in the box certifying that one will be attached to this PAS after submission. Please see directions for attaching forms if necessary.

33. For Neurological disorder

Check Yes or No

---

34. Clinical and Psychosocial Data - Please check any of the following behaviors which the individual has exhibited in the past two years:

☐ a. Substance Abuse (Identify) Select...

     Specify:

☐ b. Combative

☐ c. Withdrawn Depressed

☐ d. Hallucinations

☐ e. Delusional

☐ f. Disoriented

☐ g. Bizarre Behavior

☐ h. Bangs Head

☐ i. Sets Fire

☐ j. Displays Inappropriate Social Behavior

☐ k. Seriously Impaired Judgment

☐ l. Suicidal Thoughts, Ideations/Gestures

☐ m. Cannot Communicate Basic Needs

☐ n. Talks About His/Her Worthlessness

☐ o. Unable to Understand Simple Commands

☐ p. Physically Dangerous to Self and Others, if Unsupervised

☐ q. Verbally Abusive

☐ r. Demonstrates Severe Challenging Behaviors

☐ s. Specialized Training Needs

☐ t. Sexually Aggressive

Does the individual have Alzheimer's, multi-infarct, senile dementia, or related condition? ☐ Yes ☐ No

Other (Specify):

Figure 4.1

34. Clinical and Psychological data

Check all that apply

If substance abuse is checked, then choose substance from drop down

list. If other is chosen from the drop down, the "Specify" box is enabled. List the "other" substance there.

Does the individual have Alzheimer's, check Yes or No

PHYSICIAN RECOMMENDATION

IV. Physician Recommendation

35. Prognosis

Select...   Other: _____

36. Rehabilitative Potential

Select...

37. Diagnosis

Enter the first few characters of the ICD. Then select diagnosis from the generated dropdown listbox.

a. Primary:

b. Secondary:

c. Tertiary:

d. Other medical conditions requiring services:

Explain:

Figure 4.2

*35.	**Prognosis**	Select from the drop down box
		If other enter into text box
		Clinical note*: Terminal = applicant has a prognosis of less than 6 months to live.*
*36.	**Rehabilitative Potential**	Select from the drop down box
*37.	**Diagnosis**	▪ Primary is required ▪ Secondary and Tertiary are optional but if you enter in all available fields and need additional space you can list those is the "Explain" section **NOTE**: You can enter first few letters or numbers of diagnosis code and the names associated with your entry will populate so that you can choose the applicable diagnosis

Figure 4.3

***38.   Physician
Recommendations**

a. Check Yes or No. The options below this question will only be enabled if you choose Yes.

b. Check either A Nursing Home or B Nursing Home Waiting A/D Waiver. (In section B, only two options are enabled: Nursing Home and Nursing Home Waiting A/D Waiver.)

***39.   Certifying all
statements are
accurate**

Type physician's name, select credentials from drop down box, indicate date assessment was completed, and physician's address.

Be sure to check the box certifying that the physician listed is the physician who completed the PAS.

Once all information is filled out appropriately you can click **Submit Form**

ADDING A NOTE OR ATTACHMENT:

After you click the Submit Form button, your form will display a box below the Submit Form button entitled Add Note/Attachment. When you click this button, a box appears where you may add a note or attach documents. Indicate the name of the document and use the "browse" button to retrieve the document from its location on your computer. You may attach as many documents as necessary.

Note – If you have placed a check in any of the boxes above certifying you will attach a document a pop up will appear once you have clicked submit form. This is a reminder for you to attach your documents and you can follow the steps as presented above.

You may also indicate in the notes section that the information has been faxed (including the date faxed) and the information will be attached to the record by an APS/WVMI staff.

PRINTING

You can print a hard copy of the form you have submitted. Once your form is filled out correctly you can right click your mouse. A menu will appear as shown in figure 4.4. Click **Print** and your form will be printed. Your hardcopy will contain two signature lines, one for the applicant and one for the physician.
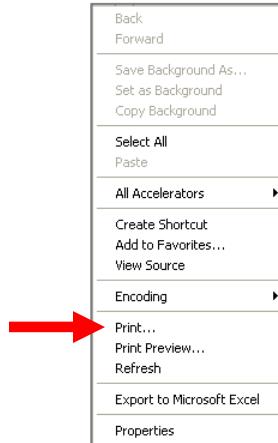
VI. Ending your session

When finished, log out by using the Logout button in the upper right hand corner of your screen, as shown in Figure 4.4.
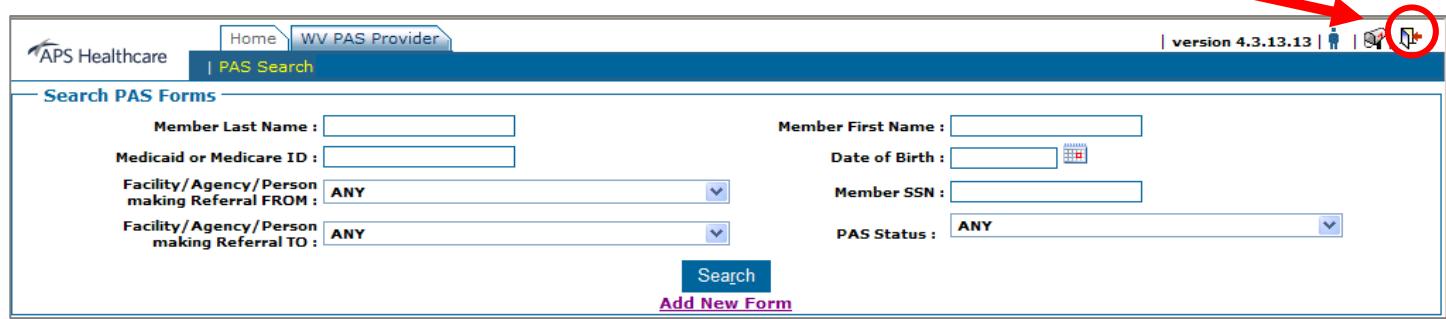
Figure 4.4

NOTE: For security reasons logout before closing the application.

APS Healthcare

APS CareConnection®
PAS for NURSING HOME CARE
WEB USER REQUEST
Please Type or Print Legibly

PROVIDER _____

ADDRESS _____

CITY _____ **STATE** ___ ___ **ZIP CODE** _____

WEB USER'S NAME_____

First Name   Middle Initial   Last Name

User's E-Mail _____

MANDATORY - Account reset information will be sent to this address – make certain it is legible and valid to ensure receipt. – MANDATORY

User's Direct Phone # & Extension: _____

For User Account Reset/Security**:**   **Significant Date (e.g. Birth Date, Anniversary Date): __ __ / __ __ / __ __ __ __**

Security Question (e.g. Name of Elementary School, Father's Middle Name) _____

_____ **Answer to Security Question:** _____

User Agreement: **I, individually and as an authorized web user of the aforementioned Provider, agree that I will access and use the information available through IRG, Inc. d/b/a APS Healthcare's secure web site only for treatment and healthcare operations purposes. I will use all reasonable precautions with respect to protecting the security of my unique login and the privacy and security of the data within this web site. By signing this request, I agree to adhere to all security and privacy requirements when using the web application, as mandated by HIPAA.**

User Signature _____ **Date** _____

APS DATA CONTACT AUTHORIZATION

DATA CONTACT'S NAME_____

Phone _____**E-Mail Address** _____

Provider's APS Data Contact Authorization: **I authorize the action indicated above for the specified User to be carried out by APS. I agree to notify APS-WV, by submitting a Request to** Cancel **the User, when a User no longer has a business purpose to access the information available within the web site.**

Data Contact's Signature _____ **Date** _____

Submit Hardcopy to APS-WV PAS User 100 Capitol St. Suite 600 Charleston WV 25301 or
Fax 866-473-2354 or **Email** Scanned/Signed Request to rajamnick@apshealthcare.com

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APS Use: **WVMIADMIN**   **APSADMIN**   **BMSPAS**

PCAPAS   **PASCLRK**   **PASPRO**   **WVMIRN**